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MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD

Leza Wainwright

SUBJECT: Implementation Update #44:
Case Management Workgroup
CAP-MR/DD Update
Unmanaged Visits for CS
Retro-Eligibility Authorizations
CS 25% Clarification
National Provider Identifier
"Incident To" Implementation

Case Management Workgroup

The Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) have convened a workgroup consisting of consumers and family members, providers, LME representatives, as well as representatives from both DMA and DMH/DD/SAS to review the enhanced service definitions. In the event that Congress does not pass a moratorium on the new Targeted Case Management regulations promulgated by the Centers for Medicare and Medicaid Services (CMS), the workgroup is reviewing and making recommendations regarding the removal of the case management components from the enhanced service definitions as well as incorporating recommendations made by the consulting firm, Mercer. The workgroup is also charged with drafting a service definition for a stand alone MH/DD/SA Case Management service that would be in compliance with the guidance issued by CMS. The workgroup has completed their review of the Community Support - Child and Community Support - Adult service definitions and is beginning their review of the remaining service definitions. Questions or comments can be sent to the workgroup chairperson, Bert Bennett at Bert.Bennett@ncmail.net.

CAP-MR/DD Update

There has been intensive work on the development of a Comprehensive Waiver and the Supports Waiver to be submitted to CMS by August 1, 2008 with implementation planned for November 1, 2008. Over the past few weeks several stakeholders have participated in various workgroups to review and discuss draft waiver documents. Public Forums were

held in locations across the state (Goldsboro, Morganton and Winston Salem) to provide stakeholders with information regarding the *proposed* waivers. Over 300 people, including individuals receiving waiver services, families, provider staff, LME staff and advocacy groups, participated in these forums.

Attached are website links to the PowerPoint presentation and the Fact Sheet handout provided at the forums. This information is in DRAFT form and staff continues to work on the development of the Supports and Comprehensive Waivers.
http://www.ncdhhs.gov/mhddsas/cap-mrdd/waiver5-08forum.pdf
http://www.ncdhhs.gov/mhddsas/cap-mrdd/waiver5-08factsheetforum.pdf

Plans of Care Reminder
All Plans of Care (Initial, CNR's and Revisions) are to be submitted to ValueOptions**.** The cost summary instructions on the web will be corrected to be consistent with this information.

Welcome
John Whittle has joined the DMH/DD/SAS Best Practices Team to provide leadership for MR/DD services. John has extensive experience working in both the community and in state developmental centers. He has served as a director of a private provider agency in delivery of community residential and vocational services. His experience also includes the writing of waiver applications to CMS as well as the design and implementation of community-based waiver systems. We welcome John and look forward to his contributions.

Unmanaged Visits for Community Support
There have been many questions surrounding the unmanaged visits for Community Support. For children and adolescents up to age twenty-one, there are eight hours or thirty-two units of unmanaged visits for consumers new to the system. New to the system means they have not previously received any mental health or substance abuse services including outpatient treatment. Adults twenty-one or older are eligible to receive four hours or sixteen units if they are new to the system. The unmanaged visits are a **once in a lifetime event.**

The Introductory Person Centered Plan (PCP) is available for use for those consumers new to the system or for those who have been discharged or not received any service for at least sixty days. The Introductory PCP should be completed for new consumers during the unmanaged visits and submitted with the ITR to ValueOptions requesting authorization for any units beyond the initial unmanaged units allotted. For those consumers who have been out of service for at least sixty days, the Introductory PCP must be completed during the first visit. It along with the ITR must be submitted that same day to request units for service delivery. Until a provider receives an authorization from ValueOptions, they are at risk for no-payment for any services delivered.

When a consumer transfers from one provider to another it is important to note, authorizations do not transfer. The first authorization to the new provider is treated as an initial authorization. If there is a complete PCP on file for the consumer, the new provider can submit an update to the PCP showing their agency as the provider of record along with an ITR to request authorization from ValueOptions. If an initial authorization is given the provider should complete a new PCP to be submitted at the first concurrent request.

Retro-Eligibility Authorizations
ValueOptions will conduct reviews for requests for those cases where a consumer has obtained Medicaid benefits and the eligibility is retroactive for dates of service that were already provided. In these cases, as soon as the provider determines a consumer has obtained retro-eligibility for Medicaid benefits, they should submit a request to ValueOptions for review. These requests should be faxed to 919-461-0679, attention to the Retro-Review Team. ValueOptions may request additional information to assist in making a decision; please provide whatever documentation is requested in a timely manner. These cases are not guaranteed authorization, but will be reviewed as any other request to see if medical necessity is met. The documentation for medical necessity such as writing a PCP, obtaining service orders, etc. must be in existence at the time of eligibility. Creating the required medical record documentation when eligibility is determined in order to obtain Medicaid funding is not allowed. This is the reason DMH/DD/SAS and DMA have always recommended that the same medical record documentation practices be in place regardless of funding source.

Community Support Service 25 Percent Aggregate Service Requirement Clarification
There continue to be questions relating to how the Qualified Professional service provision percentage requirements are calculated. Please find below some additional points of clarification:

- The 25% Qualified Professional (QP) time is required per site. Thus, if a provider has several sites within a catchment area, each site is monitored separately. The LME is only responsible for reviewing sites located within its catchment area.

- Community Support Child/Adolescent and Community Support Adult are separate services that receive distinct endorsements; thus monitoring the 25% QP time should be done separately for each service (at each site).
- The monitoring of the 25% QP time should be separated out by funding source. In the event a provider does not meet the 25% QP time for Medicaid for two consecutive months, they will lose their endorsement for that service at that site. If the 25% is not met for IPRS for two consecutive months, the provider will lose their contract for that service at that site.
- LME's will begin monitoring the 25% requirement effective with **paid claims** beginning May 1, 2008.

National Provider Identifier (NPI)

North Carolina Medicaid took proactive steps to ensure that when the National Provider Identifiers (NPIs) were implemented on May 23, 2008, providers continued to receive reimbursement for services rendered to Medicaid recipients. DMA and Electronic Data Systems (EDS) staff have received training to ensure they are able to address provider inquiries related to NPI. In addition, beginning June 9, 2008, the hours of operation for the EDS Provider Services Call Center will be extended to 5:30 p.m. This expansion of hours will be provided on a temporary basis to assist with additional NPI related calls.

As a reminder, providers should continue to submit claims with NPI, Medicaid Provider Number (MPN), and Taxonomy code(s) until your Ready Letter arrives by mail. Continuing to submit NPI, MPN and Taxonomy Code(s) in the interim will avoid any potential interruption in payment.

Behavioral Health Services Provided by Provisionally Licensed Professionals in a Physician Office

Effective July 1, 2008 LMEs will no longer be allowed to bill for services provided by provisionally licensed professionals. Effective July 1, 2008 the Division of Medical Assistance will allow the following professionals who are registered with their individual boards as provisionally licensed professionals to provide reimbursable services that can be billed "incident to" the services of a physician when the service is provided in a physician's office:

- provisionally licensed psychologists,
- provisionally licensed social workers,
- board eligible professional counselors, and;
- marriage and family therapists in the associate-licensure status.

See "Procedure Code" section below for a list of services the provisionally licensed professional may provide.

The following explains the rules and requirements for provisionally licensed professionals and the physicians who hire them and bill for their services.

In order for the above provisionally licensed professionals to provide services "incident to" a physician:

- The provisionally licensed professional
    - Must be employed by or have a contractual relationship with the physician.
    - Must practice at the same site where the physician practices.
    - May only provide services which have been determined to be medically necessary by the physician who is billing for the service.
    - Must adhere to all the rules of their individual boards relating to their provisional licensure.
    - Must only provide services that are within the scope of practice for their applicable provisional licensure.
- The physician
    - Must have a face to face visit with the consumer to determine medical necessity before the provisionally licensed professional provides services to the consumer.
    - Must be readily available to the provisionally licensed professional at all times. This means readily available by phone and able to return to the office at such time as the consumer's condition requires the return. The physician does not have to be on the same premises; however, the premises must be the location where the physician practices.
    - Must assume responsibility for the individual's work. The physician may add additional requirements for the provisionally licensed professional above and beyond those specified by the individual licensing boards at the physician's discretion.
    - Must verify licensure status upon hiring and at least annually thereafter to verify that the provisionally licensed professional remains provisionally licensed and in good standing with their individual board. Documentation must be kept to support the verification process.
    - Must verify with the licensing board the length of time the provisionally licensed professional may have a provisional license.
    - Must verify who is providing the additional clinical supervision that is required by the licensing boards that governs the provisionally licensed professional and assures the professional is receiving adequate supervision.

The physician is primarily responsible for the services delivered by any individual for which he/she has billed incident to. Additional clinical supervision must be provided according to the requirements of the individual licensing board of each provisionally licensed professional. The provisionally licensed professional will need to arrange for a qualified clinical supervisor as determined by their individual board. The board approved clinical supervisor assumes professional responsibility for the services provided by the provisionally licensed professional and spends as much time as necessary directly supervising services to ensure that recipients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The supervisor does not have to be on site unless the board requires a qualified on-site supervisor to meet the board's requirements, but must be available by phone to the professional while services are being provided. Documentation must be kept to support the clinical supervision provided in the delivery of medically necessary services as required by the licensing board.

Billing Guidelines
Reimbursement requires compliance with all Medicaid guidelines.
For billing instructions refer to:

- NC Medicaid Special Bulletin IV, May 2005 Expansion of Provider Types for Outpatient Behavioral Health Services Phase II, Billing Guidelines at http://www.dhhs.state.nc.us/dma/bulletin.htm, and
- Division of Medical Assistance Outpatient Behavioral Health Services Provided by Direct Enrolled Providers, Clinical Policy 8C, at http://www.dhhs.state.nc.us/dma/bh/8C.pdf

Procedure Codes
The following procedure codes have been added to the physician's fee schedule and must be billed with the modifier SU which indicates the services are provided in the physician's office by a provisionally licensed professional:

Code	Description
H0001	Alcohol and/or Drug Assessment
H0004	Behavioral Health Counseling and Therapy, per 15 minutes
H0004-HR	Behavioral Health Counseling and Therapy, per 15 minutes family/couple with client present
H0004-HS	Behavioral Health Counseling and Therapy, per 15 minutes family/couple without client present
H0004-HQ	Behavioral Health Counseling and Therapy, per 15 minutes group setting
H0005	Alcohol and/or Drug Services; group counseling by clinician (15 min=1 unit)
H0031	Mental Health Assessment, by non-physician

Prior Approval
Prior approval is required for services that exceed the limit of eight visits each calendar year for recipients 21 years of age and over and the limit of 26 visits per calendar year for recipients under 21. The Value Options Prior Approval Request Form must be completed by the provisionally licensed professional and signed by the MD billing "incident to". For more information on prior approval refer to:

- DMA's Outpatient Behavioral Health Services Provided by Direct Enrolled Providers, Clinical Policy 8C at http://www.dhhs.state.nc.us/dma/bh/8C.pdf
- NC Medicaid Special Bulletin IV, May 2005 Expansion of Provider Types for Outpatient Behavioral Health Services Phase II, Prior Approval Requirements at http://www.dhhs.state.nc.us/dma/bulletin.htm and
- Value Options at http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm
- Physicians who decide to employ a provisionally licensed professional must read the Value Options information in order to assure correct completion of the Outpatient Review Form (ORF2) for prior approval.

System changes will need to be made in order for claims for these services to process for payment by EDS. **Physicians should hold all claims for provisionally licensed professionals until further instruction is provided in a future bulletin article.**

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Dempsey Benton
Dan Stewart
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